Bloomfield
DENTAL CARE

Welcome! Thank you for choosing Bloomfield Dental Care, we're glad you're here. We will strive to provide you with the best possible care without pressure and advice without obligation. To help us meet all your dental health care needs, please fill out this form. If you have any questions or need assistance, please ask us- we will be happy to help.

PATIENT INFORMATION

First Name:_____ Last Name:_____ Middle:_____ Jr/Sr:_____

Social Security #:_____ Date of Birth:_____ Gender(circle one) : M F

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell:_____ Other:_____

Driver's License #_____Email Address:_____

Emergency Contact:_____Phone:_____

Preferred Pharmacy:_____Town:_____

Primary Language:_____ Interpreter Needed: Yes No

How did you hear about us? _____

INSURANCE INFORMATION

Do you have Dental Insurance(circle): Yes No

Primary Insurance		**Secondary Insurance**	
Subscriber Name		Subscriber Name	
Subscriber ID#		Subscriber ID#	
Date of Birth		Date of Birth	
Insurance Group #		Insurance Group #	
Insurance Phone#		Insurance Phone #	

For your convenience we also offer the following methods of payment. Please circle the option you prefer.

Cash *Personal Check* *Debit/Credit Card* *Care Credit*

Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with _____(name of insurance co.) and assign directly to Bloomfield Dental Care all insurance benefits. If any, for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above mentioned dental facility may use my healthcare information and may disclose such information to the above mentioned company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services. This content will stay in effect as long as payments for rendered services have been payed off and I am a patient with Bloomfield Dental Care.

_____ _____ _____

Signature of Patient, Parent or Guardian Relationship to the patient (if under 18 years old) Date